RETURN TO: ATTN EXCEPTIONS UNIT MO HEALTHNET DIVISION PO BOX 6500 JEFFERSON CITY, MO 65102-6500

FAX NO: 573-522-3061

PRETICIPANT DIAMNOSES QUEST RELATE TO ITEMS) OR SERVICE(S) REQUESTED) RECURSTED SERVICE DATES SETIMATED DURATION OF NEED SETIMATED DURATION	PL	EASE TYPE OR PRINT. ALL IN	FORMATION I	MUST BE SI	UPPLIED OR THE REQUE	ST WILL N	OT BE PROCESSED		
PRessel is the primary wound type; (i.e. Anferial ulcer, Diabete Uloer, Necrotzing fascilitis, amputation - diabetic, amputation - Baumatic, Durns, checked, post-op flap or graph, pressure ulcer state iil or IV, Studgost non definited, traums-orthogedic or soft fissus open, venous states ulcer etc.) WOUND INFORMATION: Surgical Wound	PARTICIPANT NAME			DOB		PARTICIPANT MO HEALTHNET NUMBER (DCN)			
Please list the primary wound type: (i.e. Arterial uloer, Diabetic Ulcar, Necrotizing fascilitis, amputation - diabetic, amputation - traumatic, burns, dihesced, post-op flap or graph, pressue uses state life in IV, Surgicia non defisioed, traume-orthopedic or soft tissue open, ventous states sider etc.) WOUND INFORMATION: Surgicial Wound	PARTICIPANT DIAGNOSES (MUST RELATE TO ITEM(S) OR SERVICE(S) REQUESTED)) HCPCS COI		AND DESCRIPTION		
WOUND INFORMATION: Surgical Wound	REQUESTED SERVICE DATES				E	STIMATED D	URATION OF NEED		
Surgical Wound				•		itation - trau	matic, burns, dihesced, post-op flap or graph,	_	
Neuropathic Wound	WOUND INFORMATION:							_	
Venous Stasis Ulcer If Yes, are compression bandages/garments consistently applied?	Surgical Wound If Yes, type of surgery [ery	Dat	te of Dehiscence		
Pressure Ulder	Neuropathic Wound If Yes; on a comprehensive diabetic manage				ım	Blo	od sugars controlled?		
It No, what nutritional status adequate for healing? Yes	Venous Stasis Ulcer If Yes, are compression bandages/garments				applied?	Are	e leg(s) elevated?		
Have wound dressings been applied to maintain a moist wound environment? Yes No If No, why?	Pressure Ulcer	_ If Yes; is a Support Surface b	eing used?	Kind/name being used					
Is untreated osteomyelitis present within the vicinity of the wound? Yes	Is participant's nutritional status	adequate for healing? Yes		□No	If No, what nutritiona	l measures	have been taken?		
Yes	Have wound dressings been ap	plied to maintain a moist wound	environment?	☐ Yes	☐ No If No, why?				
If yes, specify location/proximity to wound: Was NPWT initiated in an inpatient facility? Facility Name Date NPWT initiated	Is untreated osteomyelitis present within the vicinity of the wound? Yes No				·				
What is the medical necessity for accelerate formation of granulation tissue which cannot be achieved by other available topical wound treatments? List all treatments/dressing tried prior to NPTW: Please provide current wound(s) information below: Evaluation Date Location Stage Size in centimeters L x W x D Description	•	, ,	he wound? [Yes	No			_	
Evaluation Date Location Stage Size in centimeters L x W x D Description MO HEALTHNET PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER) NAME TELEPHONE NUMBER ADDRESS FAX NUMBER PROVIDER NPI PROVIDER NPI PROVIDER TAXONOMY CODE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER FAX NUMBER FAX NUMBER FAX NUMBER FAX NUMBER PROVIDER TAXONOMY CODE	List all treatments/dressing tried	I prior to NPTW:							
MO HEALTHNET PROVIDER WHO WILL BE DISPENSING AND BILLING FOR SERVICES (EX. DME PROVIDER) NAME TELEPHONE NUMBER ADDRESS FAX NUMBER PROVIDER NPI PROVIDER TAXONOMY CODE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER FAX NUMBER FAX NUMBER PROVIDER TAXONOMY CODE	·	1	Star	Size in contimeters		W×D	Description		
ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER TELEPHONE NUMBER TELEPHONE NUMBER FAX NUMBER FAX NUMBER FAX NUMBER PHYSICIAN NPI PHYSICIAN TAXONOMY CODE	Evaluation Date	Location	Stat	ye	Size in centimeters L x	WAB	Description	_	
ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER TELEPHONE NUMBER TELEPHONE NUMBER FAX NUMBER FAX NUMBER FAX NUMBER PHYSICIAN NPI PHYSICIAN TAXONOMY CODE									
ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER TELEPHONE NUMBER TELEPHONE NUMBER FAX NUMBER FAX NUMBER FAX NUMBER PHYSICIAN NPI PHYSICIAN TAXONOMY CODE									
ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER TELEPHONE NUMBER TELEPHONE NUMBER FAX NUMBER FAX NUMBER FAX NUMBER PHYSICIAN NPI PHYSICIAN TAXONOMY CODE									
ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER TELEPHONE NUMBER TELEPHONE NUMBER FAX NUMBER FAX NUMBER FAX NUMBER PHYSICIAN NPI PHYSICIAN TAXONOMY CODE									
ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID PROVIDER NPI PROVIDER NPI PROVIDER TAXONOMY CODE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER DOCTOR'S ADDRESS OR APN'S ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID PHYSICIAN NPI PHYSICIAN TAXONOMY CODE		MO HEALTHNET PROVIDER W	HO WILL BE I	DISPENSING	G AND BILLING FOR SEF	VICES (EX	. DME PROVIDER)	_	
MO HEALTHNET PROVIDER ID PROVIDER NPI PROVIDER NPI PROVIDER TAXONOMY CODE DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER FAX NUMBER MO HEALTHNET PROVIDER ID PHYSICIAN NPI PHYSICIAN TAXONOMY CODE	NAME						TELEPHONE NUMBER		
DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELEPHONE NUMBER DOCTOR'S ADDRESS OR APN'S ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID PHYSICIAN NPI PHYSICIAN TAXONOMY CODE	ADDRESS						FAX NUMBER		
DOCTOR'S ADDRESS OR APN'S ADDRESS FAX NUMBER MO HEALTHNET PROVIDER ID PHYSICIAN NPI PHYSICIAN TAXONOMY CODE	MO HEALTHNET PROVIDER ID			PROVIDER NPI			PROVIDER TAXONOMY CODE	_	
MO HEALTHNET PROVIDER ID PHYSICIAN NPI PHYSICIAN TAXONOMY CODE	DOCTOR'S NAME OR ADVANCED PRACTICE NURSE'S (APN) NAME AND TITLE TELE				JMBER			_	
	DOCTOR'S ADDRESS OR APN'S AI	DDRESS					FAX NUMBER	_	
DOCTOR'S OR APN'S ORIGINAL SIGNATURE AND TITLE DATE	MO HEALTHNET PROVIDER ID			PHYSICIAN NPI			PHYSICIAN TAXONOMY CODE	_	
	DOCTORIO OR ARNIC ORIGINAL O								